Clinical Translation
Request for Applications
Clinical Acceleration Team Award (CATA)
Funding Stream
Cohort 2
Version 1.0 - April 2026

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1. INTRODUCTION

1.1. Purpose

This document is intended to aid Investigators wishing to apply for a Clinical Acceleration Team Award (CATA).

CATA projects are designed to accelerate the clinical integration of biomarkers and therapeutic strategies by supporting rigorously designed, hypothesis-driven studies that generate high-quality clinical and correlative evidence. A core objective of the program is to enable trials that inform future interventional strategies, optimize patient management and support the development of biomarker-guided clinical pathways through the generation of fit-for-purpose evidence.

1.2. Clinical Translation

OICR's Clinical Translation (CT) theme advances cancer research toward meaningful clinical impact. It supports preclinical and early clinical studies that develop and validate new approaches to detect, treat and monitor cancer at its earliest and most actionable stages. Through close partnership with patients, clinicians and researchers, CT helps ensure that clinically relevant, high-potential innovations are positioned for patient and health care impact.

For more information, visit:

- OICR's website
- Clinical Translation's website
- Clinical Translation Pathway's website for past CATA (Cohort 1) supported trials

2. REQUEST FOR APPLICATIONS (RFA)

2.1. Scope

Molecular (sometimes referred to as minimal) residual disease (MRD) refers to the detection of tumour-derived molecular signals that indicate persistent, occult or treatment-resistant systemic disease in patients with a non-metastatic cancer diagnosis. In this RFA, MRD is defined broadly and may be assessed at clinically meaningful timepoints before or after definitive local therapy. This includes, but is not limited to, circulating tumour DNA (ctDNA) measured following surgery or systemic therapy, as well as ctDNA measured prior to definitive surgery (e.g., during or after neoadjuvant therapy or at diagnosis) where it is used to inform prognosis, risk stratification, response assessment or therapeutic decision-making. The defining feature is not the timing of assessment, but its intended role in guiding or informing clinical management.

MRD has emerged as a promising biomarker across hematologic malignancies and solid tumours. While increasing evidence supports its clinical validity in several settings, definitive demonstration of clinical utility, particularly in solid tumours, often requires large, practice-changing trials that may not be feasible within the scale and duration of CATA funding. Accordingly, this RFA recognizes that supported studies may not be powered to demonstrate improvements in long-term survival endpoints. Instead, trials should be designed to generate rigorous prospective evidence that advances the evidentiary pathway toward clinical qualification, integration into care or a subsequent definitive trial.

Through prior CATA investments in MRD-focused clinical trials (CATA Cohort 1), Clinical Translation has supported early integration of MRD into prospective interventional designs in lung, head and neck and breast cancer. These experiences have highlighted both the promise of MRD-informed strategies and the operational and methodological challenges of implementing them. Lessons learned include the importance of clearly defining the intended role of MRD within the study design;

prespecifying the clinical decision algorithm triggered by MRD results; selecting fit-for-purpose assays with appropriate analytical performance characteristics and turnaround times; and ensuring that MRD workflows are compatible with trial timelines and multicentre execution.

CATA Cohort 2 will support prospective clinical trials in which MRD assessment is a prespecified and integral component of the study design, and in which MRD results are explicitly linked to defined clinical decision points, management strategies or treatment adaptations (including escalation, de-escalation, modification, duration optimization or avoidance). The intent of this cohort is to support well-designed, decision-relevant studies that meaningfully advance MRD as a clinically actionable biomarker and contribute to the cumulative evidence required for future definitive evaluation and broader clinical adoption.

Trials eligible under CATA Cohort 2 include prospective clinical studies that:

- Integrate MRD as a prespecified and integral component of the study design, with clear justification of its intended clinical role.
- Link MRD results to predefined clinical decision algorithms, management strategies or treatment adaptations (including escalation, de-escalation, modification, duration optimization or avoidance).
- Evaluate MRD at clinically meaningful timepoints, which may occur before or after definitive local therapy (including pre-surgical, post-neoadjuvant, post-operative or during adjuvant therapy or follow-up settings).
- Assess endpoints appropriate to the trial scale, which may include survival outcomes, recurrence or molecular relapse, response depth, treatment exposure, safety, feasibility or validated surrogate or intermediate endpoints capable of generating decision-relevant evidence.
- Incorporate patient-reported outcomes, where feasible, to assess the impact of MRD-informed clinical decision-making on patient experience.
- Generate high-quality prospective clinical and correlative data that advance the evidentiary pathway toward biomarker qualification, clinical integration or a subsequent definitive interventional trial.
- Employ fit-for-purpose assays with clear justification of analytical and clinical validity, performance characteristics and operational feasibility within the proposed study context.
- Demonstrate operational readiness, including necessary site commitments and feasibility such that study completion can occur within the CATA funding timeframe.

Studies that meet these criteria will be evaluated for their potential to advance MRD-informed patient care and to generate high-quality translational evidence suitable for guiding subsequent clinical development and implementation.

Concepts will be reviewed for scientific merit, feasibility and alignment with CATA Cohort 2 scope. Selected Concepts will be invited to submit a full trial application, including a complete protocol, detailed budget, timelines, milestones and deliverables.

CATA encourages pragmatic, scalable trial designs, including decentralized or hub-and-spoke frameworks, that support equitable patient access, standardized MRD sampling and robust, feasible multicentre collaboration. Importantly, investigators from CATA Cohort 2-supported trials will be invited to contribute operational insights or best practices to future coordination/harmonization activities related to MRD.

2.2. Eligibility

Investigators at Ontario academic centres, hospital research institutes or other government research institutions are eligible to submit trial Concepts for prioritization consideration. Concept submissions must include investigators/team members from **multiple centres**, **as well as a patient partner**. **OICR funding is only tenable in Ontario.**

Investigators may submit a maximum of **one application** as Principal Investigator (PI) or Co-Principal Investigator (Co-PI). Investigators may, however, participate in additional applications as a Co-Investigator or Collaborator. With a focus on building MRD study capacity in Ontario, inclusion of early career investigators/clinicians, particularly those from historically under-represented communities, is strongly encouraged.

For-profit entities are **ineligible** to receive OICR funding. Any trial whose personnel or host institution are receiving concurrent support from the tobacco industry (including companies or corporate divisions that directly manufacture or purchase tobacco for production, or market tobacco products, including the Council for Tobacco Research or the Smokeless Tobacco Council) are **ineligible** for OICR funding.

2.3. Term

Proposals selected for funding will be provided with a funding term of up to four years, starting January 1, 2027, and ending no later than December 31, 2030.

2.4. Funding available

The total funding envelope available is approximately $6M, with the intent to support three to four clinical trials, at a budget range of approximately $1.3M to $1.5M per study. While no formal minimum or maximum trial budget has been established, applicants are expected to request funds that are appropriate to the scope and complexity of the proposed trial and to ensure that all proposed costs are transparent, well-justified (per line-item) and aligned with the study objectives. Applications requesting amounts outside of the anticipated range must ensure that the justification is clear and compelling.

Budgets will be reviewed at the Concept stage and discussed in detail during the prioritization review meeting with the review committee. Feedback will be used to develop Full Application budgets. Final awarded budgets will be informed by feedback from the review process and contingent on the total funding envelope.

All expenses must adhere to OICR's guidelines for eligible expenses, located on the OICR Funding Opportunities website, for clinical/health intervention trials. It is expected that the bulk of the OICR funding request would support trial operations, rather than procured goods or services (e.g., drugs, commercial ctDNA tests). **OICR does not provide overhead for any CATA clinical trial, irrespective of expense type.**

The following expenses are not eligible under this RFA:

- Commercial MRD assays

2.5. Timeline

Information session (optional)*:	June 3, 2026, 2-3 p.m. ET
Concept submission deadline:	July 30, 2026, by 5 p.m. ET
Concept feedback to teams:	Week of September 14, 2026
Prioritized Concept meetings**:	September 30, 2026

Full Application deadline:	October 29, 2026, by 5 p.m. ET
Notification of decision:	December 2026
Funding start date:	January 1, 2027

Information session: **Register here. Attendance is optional and the session will be recorded and posted on the OICR Funding Opportunities website.*
***Prioritized Concept meeting attendance is mandatory for prioritized Concept teams*

Funding agreement execution: Funding agreements with the host institution(s) must be fully executed no later than January 30, 2027. It is the obligation of the applicant to ensure that Research Offices are made aware of this condition prior to Concept submission. Failure to execute the funding agreement within said timeframe will forfeit the award.

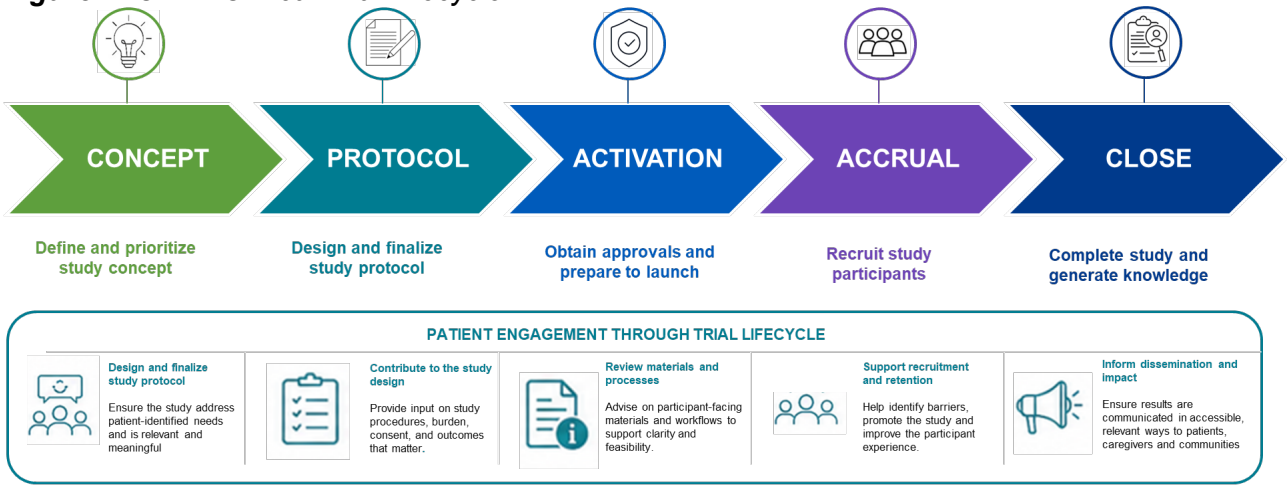
For any questions, please refer to the FAQ page before contacting the OICR Scientific Secretariat office (ScientificSecretariat@oicr.on.ca).

2.6. Application requirements

Patient partners
Patient perspectives and insight can be transformative to research planning, execution and knowledge transfer. Patient partnership in OICR-supported research ensures i) studies meet the needs of the people intended to benefit, ii) studies benefit from the integration of patient perspectives, and iii) study activities and results are communicated in an accessible way to patients, caregivers and the wider community.

All CATA trials must include a patient partner as part of the team and include a patient partnership plan, developed together with the patient partner. The patient partnership plan must align with the CATA Clinical Trial Lifecycle (**Figure 1**) where patient partners are engaged throughout the trial lifecycle to enhance study design, maximize accrual and ensure that results are disseminated in an accessible way to patients, caregivers and the wider community.

***Figure 1:** CATA Clinical Trial Lifecycle*



Trial teams can explore patient engagement resources on OICR's Patient Partnership page, the Canadian Cancer Clinical Trials Network and on their home institution's website. Trial teams should first look to their home institution for recruiting patient partners. If support is required to identify a

patient partner, reach out to Justin Noble, Patient Partnership and New Initiatives Lead (jnoble@oicr.on.ca).

Equity, Diversity and Inclusion (EDI)
All OICR-supported research is expected to align with the Institute's principles of Equity, Diversity and Inclusion (EDI). OICR's Commitment to EDI in Research Statement and guidelines on *Equity, Diversity, and Inclusion Tactics in Research* are located on the OICR Funding Opportunities website.

OICR's expectations for EDI in clinical research are aligned with evolving international regulatory standards, including guidance from Health Canada and the U.S. Food and Drug Administration (FDA), which emphasize the importance of collecting and analyzing disaggregated demographic data to support equitable, evidence-based decision-making. Clinical trials should collect standardized demographic data (e.g., age, sex, gender, race and ethnicity) and analyze and report these data to the extent feasible. These expectations apply across the clinical development continuum, including early-phase, exploratory and confirmatory trials, recognizing that the nature and depth of analysis will vary by trial phase, size and objectives.

Where appropriate, applicants are encouraged to consider whether decentralized or hybrid trial elements (e.g., local assessments, remote consent or follow-up, flexible visit schedules) should be considered as mechanisms to reduce geographic, logistical or structural barriers to participation. Relevant guidance includes resources from Clinical Trials Ontario, Health Canada and 3CTN on decentralized and hybrid clinical trial models.

Through this approach, OICR aims to ensure that all supported clinical trials are scientifically rigorous, ethically grounded and aligned with emerging regulatory expectations for equity, transparency and inclusion across the cancer research continuum.

Declaration of Research Assessment (DORA)
OICR is a signatory to the Declaration of Research Assessment (DORA). As such, we are aligned with DORA principles through our commitment to assess the quality and impact of scientific research through means other than journal impact factors. As part of OICR's commitment to these principles, applicants are asked NOT to include journal impact factors (JIF) or other journal-based metrics in any document submitted as part of the application process.

Use of Artificial Intelligence (AI)
OICR aligns with the Canadian federal research funding agencies ("the agencies") Guidance on the use of Artificial Intelligence in the development and review of research grant proposals. As part of the application process, applicants will be required to clearly state if and where application material has been generated by AI.

Clinical Trial Registration and Results Disclosure
As part of the Full Application, the lead applicant (PI) must attest that any clinical trial supported through this RFA will be conducted in alignment with Tri-Agency policies, Health Canada requirements and ICH GCP guidelines, including registration of the trial on a publicly accessible clinical trial registry prior to participant enrollment and public disclosure of results.

Sensitive Technology Research and Affiliations of Concern (STRAC)
In alignment with the Tri-agency, OICR has adopted the Government of Canada's Policy on Sensitive Technology Research and Affiliations of Concern. Applicants must state whether the proposal involves research that advances a sensitive technology research area, and if so, must provide the STRAC attestation form for each named PI(s), Co-PI(s) and Co-Investigator(s) on the team.

Use of OICR's Collaborative Research Resources
OICR helps to enable research in Ontario by providing expertise, advice and access to research services. Researchers can benefit from OICR's high-end technology infrastructure, world-leading research knowledge, and high-quality services and support. Where appropriate, teams are to consider collaborating with OICR investigators or leveraging use of OICR's Collaborative Research Resources.

2.7. Overview of application requirements using OICR's online submission system

CATA trials are a two-step process including a trial Concept submission and a penultimate trial protocol and associated documents as part of the Full Application stage.

1. **Concept submission:**
   - Applicants submit a Concept outlining their proposed trial, clinical merit, feasibility and alignment with program scope.
   - Letters of Support will be important in supporting trial feasibility.

2. **Full Application (by invitation only):**
   - Selected trial Concepts will be invited to submit a Full Application that expands on the initial Concept submission and addresses feedback provided during the review process.

All stages are to be submitted using ReportNet, OICR's online system for managing grants and awards. For clarity, the 'Concept submission' stage will utilize the 'Letter of Intent (LOI)' form and process within ReportNet. Refer to OICR's guidelines on using ReportNet for additional information.

2.8. Accessibility and accommodations

Providing an accessible experience is important to OICR. If you require an accommodation in order to prepare or submit an application, or if you require documents or materials in an alternative format, please contact the Scientific Secretariat (ScientificSecretariat@oicr.on.ca). More information on OICR's Accessibility Plan can be found on our website.

2.9. Completing a Concept submission (i.e., a 'LOI' in ReportNet)

Application information
The system will pre-populate the PI's information from their ReportNet profile. Applicants will not be able to submit without first completing their user profile, including the demographic questions.

Required fields are marked with a red asterisk in ReportNet. Word/page counts, where applicable, are noted. Investigators and other collaborators can be added to the submission using the 'Invitations' tab on the left side of the screen.

- **Project title**
- **Start date:** Enter a funding start date for the application, no earlier than January 1, 2027.

- **End date:** Enter a funding end date for the application, no later than December 31, 2030; can be a maximum of four (4) years after the start date.
- **Application type:** Select 'CATA'.
- **Key words**
- **Cancer type**

Summary information

- **Lay summary (max. 500 words):** The lay summary MUST be co-written together with the trial team's patient partner. It should outline the clinical research question, what the trial will do to answer the question, what will be measured, why the findings matter and how the findings will be used (near and longer term). It should be written in plain language that can easily be understood by non-scientists, devoid of acronyms and scientific/technical jargon. The lay summary is unlike a scientific abstract, which is written for subject peers. It will be used by patient partners during the review process. The lay summary may be shared with external parties for communications and reporting purposes, and with reviewers to identify potential conflicts of interest. If funded, the lay summary may be used to communicate the trial to the public. As such, both the trial title and the lay summary should be considered non-confidential.

Study description

The following sections should demonstrate that the proposed trial is scientifically rigorous, clinically justified and positioned to generate evidence that advances MRD toward clinical validation, decision-making and patient impact.

- **Background and rationale (max. 500 words):** Provide a concise overview of the clinical and scientific background underpinning the proposed study, clearly articulating the unmet clinical need within the proposed disease setting. Applicants must describe the current role and level of maturity of MRD in this disease area, including how MRD is currently being used (or not used) in clinical research and practice. The Concept should summarize the current clinical, translational and regulatory landscape, including relevant ongoing or completed trials, emerging evidence and areas of uncertainty related to MRD in the context of the disease. Concepts should state the specific MRD-related hypothesis being tested and provide the rationale for using MRD in the proposed study, supported by relevant preclinical, translational or clinical evidence. A brief overview of the current standard of care should be included, along with a clear explanation of how the proposed trial advances existing knowledge, addresses gaps in the MRD landscape, or has the potential to inform future clinical practice.
- **Relevance to program scope (max. 250 words):** Describe how the proposed trial aligns with the goals, priorities and focus areas of CT and this MRD-focused CATA. This should include a clear description of how MRD is being used to address a clinically meaningful question and how the trial supports implementation, validation or clinical decision-making related to MRD. Applicants should explicitly state how the trial contributes to advancing MRD from an investigational biomarker toward clinical utility, health system adoption or regulatory relevance, as appropriate for the study phase.
- **Path to clinical and patient impact (max. 250 words):** Outline the anticipated path to clinical, patient and/or health system impact following completion of the study. Describe how study results could inform clinical decision-making, trial design, regulatory pathways, guideline development or future phase II/III trials. Where applicable, describe how MRD findings may accelerate therapeutic optimization, de-escalation or escalation strategies or precision medicine approaches.
- **Synopsis (max. 500 words):** Provide a structured synopsis including:
  - Disease setting and clinical context

- Objectives and primary hypothesis
- Patient population and key eligibility criteria
- Trial design and intervention(s)
- Endpoints, including clearly defined MRD-based endpoints (primary, secondary, exploratory or surrogate, as applicable), and, where appropriate, patient-reported outcomes
- Correlative studies and biomarker analyses

Note: A study schema must be uploaded under the 'Attachments' section.

- **Methodology and MRD assessment strategy (max. 500 words):** Describe the overall study methodology and scientific approach. This section must present an MRD assessment strategy that is scientifically justified and appropriate to the study objectives, disease context and trial phase. Concepts should include:
  - MRD assay(s) or platform(s) to be used and the clinical or biological rationale for the proposed MRD approach, including its suitability for the target tumour type, disease stage and clinical setting.
  - Biological sample type(s) and planned collection timepoints in relation to treatment and clinical endpoints.
  - Clearly defined MRD-based endpoints (primary, secondary, exploratory or surrogate, as appropriate) and their role in testing the study hypothesis.
  - Analytical performance characteristics of the proposed assays relevant to the intended context of use (e.g., sensitivity, specificity, limit of detection).
  - The degree of assay standardization and validation, justified in relation to the trial objectives and stage of development.
  - Planned correlative or translational analyses integrating MRD with clinical outcomes, where applicable.

  Note: This section should focus on the scientific and methodological validity of the MRD approach and its ability to address the proposed hypothesis. Operational, logistical and start-up considerations should not be included here and will be assessed separately under 'Study feasibility'.
- **Statistical considerations (max. 300 words):** Provide an overview of the statistical approach, including the rationale for study design, sample size considerations and analytical methods. Describe how clinical and MRD data will be analyzed and interpreted in relation to clinical outcomes. Detailed statistical analysis plans will be required at the Full Application stage.

Study feasibility

- **Multicentre trial design and feasibility (max. 500 words):** Given the logistical and operational complexities of MRD-enabled clinical trials, particularly with regulatory oversight, assay strategy, data coordination, patient accrual, standardized biospecimen handling and key determinants of success, operational feasibility is a core component of CATA evaluation. CATA MRD trials must be multicentre and are encouraged to consider a decentralized or hub-and-spoke trial framework for study activities which may include:
  - Hubs: Provide centralized leadership and oversight, assay strategy, data coordination.
  - Spokes: Including community oncology centres, regional hospitals and affiliated clinical sites, contribute to patient identification, enrolment, clinical follow-up and standardized sample collection.
  - Satellite sample collection centres: Community laboratories, outpatient clinics or mobile phlebotomy services, may be incorporated to facilitate patient access and ensure adherence to timely MRD sampling schedules.
  - Outline the multicentre trial design and highlight past experience working together.
- **Engaged sites and infrastructure readiness (max. 500 words):** Identify all participating sites and describe their readiness to conduct MRD-enabled clinical trials, including access to required

patient populations, specimen collection and processing capabilities, laboratory infrastructure and data systems. Applicants should clearly indicate which sites are confirmed and ready to activate, and describe any centralized or harmonized infrastructure (e.g., central labs, biobanking, MRD assay coordination) that supports timely trial initiation and consistent MRD assessment across sites. Importantly, this section should identify and describe the role of the study sponsor, including central data coordination and monitoring.

- **Study team and governance (max. 500 words):** Describe the composition, expertise and roles of the study team, highlighting MRD-specific scientific, clinical and methodological expertise. Applicants should clearly identify leadership roles and responsibilities across participating sites. Outline the study governance and oversight structure, including decision-making processes, data and safety monitoring and mechanisms to ensure protocol adherence, data integrity and consistent MRD assay quality across sites. Applicants must demonstrate that the team has the experience, infrastructure and operational capacity to deliver a multicentre, MRD-enabled clinical trial on schedule, from activation through completion within four years, with readiness to initiate enrollment in line with program timelines. Although patient partners are part of the trial team, information about their role and integration is to be outlined below, as part of 'Patient partnership plan'.
- **Patient recruitment (max. 500 words):** Provide a detailed recruitment plan, including the anticipated eligible patient population, projected accrual rates per site and justification based on historical performance or current clinic volumes. Applicants must identify competing trials or standard-of-care changes that could impact recruitment and outline mitigation strategies. The plan should demonstrate that first patient enrollment **within seven months of award activation** is feasible and that accrual targets can be met within the proposed timelines.
- **MRD assay readiness, operational feasibility and provider engagement (max. 500 words):** Describe the practical implementation and readiness of the proposed MRD strategy, including:
    - **MRD assay readiness and engagement:** Highlight discussions/agreements with assay providers regarding availability, support, turnaround times (if applicable) and in-kind support (if applicable).
    - **Laboratory capacity and infrastructure:** Personnel, equipment and workflow readiness at participating sites as well as central labs to support timely MRD testing and reporting.
    - **Sample handling and logistics:** Collection, processing, storage, shipping and integration with multicentre clinical workflows.
    - **Assay performance in practice:** Expected turnaround times and compatibility with clinical decision-making or trial operations. Include any plans for quality assurance, inter-site reproducibility and data integrity.
    - **Dependencies, risks and mitigation strategies:** Identify potential barriers to assay implementation that could impact trial start-up or enrollment, including logistical, regulatory or operational factors and outline mitigation approaches.

  Applicants must demonstrate that the MRD strategy is operationally feasible and sufficiently validated and available such that assay implementation will not delay trial activation and that the first patient can be enrolled **within seven months of award activation**. Where applicable, indicate how the assay plan integrates with multicentre or decentralized/hybrid trial approaches to ensure consistent and timely MRD measurements across sites.
- **Study timelines (max. 500 words):** Provide milestone-driven timelines outlining key study start-up, conduct and completion activities (bullet format is acceptable; broken up for each year of the study). Timelines should demonstrate that the trial is operationally ready and in line with Clinical Translation's Clinical Trial Timeline of site activation within 180 days of funding start and first patient enrolled 30 days following. At a minimum, timelines should address:
    - Final protocol and study document readiness

- Drug availability and access, including confirmation of supply aligned with proposed start-up timelines
- MRD assay availability and readiness, including assay set-up, validation (if required) and integration with clinical workflows
- Ethics and regulatory submissions and approvals
- Site initiation and activation across participating centres, including any phased or staggered activation plans
- Planned date for first patient enrolled and last patient accrued, with justification based on recruitment projections

- **Interim analysis and go/no-go decision(s) (max. 500 words):** This section should identify critical path dependencies, including any approvals or logistical steps that could impact trial start-up or MRD implementation, and describe contingency plans to mitigate delays. Where decentralized or hybrid trial elements are proposed, timelines should reflect any additional set-up requirements and demonstrate that these approaches support, rather than delay, trial initiation. Note that these timelines will be used to develop a deliverables and milestones document for the Full Application which will become a schedule to the award agreement and used by Clinical Translation staff to track study progress.
- **Approvals (max. 500 words):** At the Concept stage, applicants should describe the anticipated approvals and stakeholder alignments required to initiate the study. This includes institutional ethics, cooperative group, sponsor/pharma or regulatory approvals as applicable. Applicants should summarize any preliminary discussions or expressions of support that demonstrate feasibility and readiness to progress to Full Application. Where relevant, note considerations for MRD assay implementation, multicentre coordination or decentralized/hybrid trial elements. While formal approvals are not required at the Concept stage, pathways should be realistic and unlikely to delay first patient enrollment within seven months of award activation.
- **Pharma engagement and drug safety profile (max. 500 words):** At the Concept stage, applicants should summarize any engagement with pharmaceutical partners, including preliminary discussions regarding the study concept, study schema and anticipated drug availability. Where relevant, note any non-confidential safety information and confirm that planned drug supply aligns with proposed study timelines. It is strongly advised that evidence of support or letters of intent from partners be included as attachments to demonstrate feasibility. While formal approvals are not required at the Concept stage, the summary should provide confidence that drug access and partner engagement as well as Health Canada CTA are realistic and will not delay trial start-up or first patient enrollment within seven months of award activation. Formal commitments, if not available at the Concept stage, will be required during the Full Application review process.

Additional information

- **Patient partnership plan (max. 500 words):** Integrating patient perspectives and insight can be transformative to clinical trial planning and execution. Provide a patient partnership plan that aligns with Section 2.6 above. This section must be written as a stand-alone piece, assuming that the lay readers have read the lay summary but may not have read the full study description. It should be written in clear, easy to understand, lay language. The patient partnership plan must be **developed together with the patient partner.** It should include:
  - Information about the patient partner(s) that have been, and will be, partnered with on the project.
  - Roles and responsibilities of the patient partner(s), which must include, but are not limited to, supporting i) protocol design (e.g., potential challenges of protocol design to participating patients, accrual strategy, selection of PRO outcomes if included); ii) review of all patient-facing materials such as the informed consent form, iii) clinical trial execution (e.g.,

identifying solutions to potential patient barriers, developing plans to reach patient communities), iv) results reporting (e.g., developing plain language communication material).

In addition to the plan, the patient partner is strongly encouraged to provide a **separate letter of support** which can be uploaded in the 'Attachments' section of the submission.

Concept checklist

Applicants must confirm that their Concept meets the criteria of the CATA funding stream. Concepts that do not meet these requirements may be deemed out of scope or not feasible and may not be reviewed by the panel or advance to the Full Application.

- MRD is central to the study and addresses a clinically meaningful question.
- A clear MRD-related hypothesis and fit-for-purpose MRD strategy are described.
- Proposed trial is multicentre, with plans to include patients beyond major academic centres.
- Trial oversight to ensure study is completed within four years.
- MRD assay access is feasible, with evidence of assay readiness and provider engagement.
- Proposed clinical intervention is appropriate, acceptable, and any safety considerations are adequately addressed.
- Proposed timeline supports first patient enrollment within seven months of award activation.
- Required Letters of Support are included, as applicable, from key partners confirming feasibility and resource availability.

Attachments

- **Figures, tables and references:** Upload as one PDF.
- **Study schema:** See 'Synopsis' above. Upload as one PDF.
- **Letter(s) of support (LOS):** Applications must have documented LOS from key partners. Upload as one PDF. LOS may include:
  - Letters from pharma partners
  - Letters from patient partners
  - Relevant approvals
- **Budget,** using the Excel template provided (upload as both an Excel and PDF file)
  - Download the budget template provided in the application and complete the budget request details. Expenses must adhere to OICR's guidelines for eligible expenses, located on the OICR Funding Opportunities page. **Note that OICR does NOT provide overhead on any component of clinical trials.**
  - Justification must be provided for each line item (i.e., add in details in the justification column).
  - The 'Other contributing funds' section should be completed as applicable. Include all leveraged funds (cash or in-kind).
- **Publications:** Compile and upload the top three publications relating to the study that reviewers should take special note of. Upload as one PDF.
- **Curricula Vitae (CVs):** Compile CVs (abbreviated CVs are encouraged) for PIs, Co-PIs and Co-Investigators and upload as one, bookmarked PDF. CVs can be in any format, but must be brief (no more than five pages), and address:
  - Core CV elements: Education/training, employment, honours and awards, professional affiliations, funding in the past five years, outputs (e.g., publications, IP, presentations, etc.)
  - Relevant experience for this application, including clinical trial experience/leadership and MRD experience.

Host institution information

- Provide the contact details for the host institution administrative authority at the PI's (and any named Co-PI(s)) institution(s).
- Using the PDF form provided, the applicant must obtain the signature of the institutional administrative authority attesting to the terms outlined in the form. Additional forms must also be signed from the Host Institution of any Co-PIs. If the host institution for a PI or Co-PI is OICR, an attestation form from OICR is not required Combine all attestations and upload as one, bookmarked, PDF.

Once all required fields are completed, select the 'Submit LOI' button at the bottom of the screen.

2.10. Completing a Full Application

Information provided at the Concept stage will be carried over to the Full Application form and will be editable. Only applicants invited to submit a Full Application following the Concept review will be provided with access to the Full Application form.

In addition to the information collected at the Concept stage, the following information will be required for a Full Application:

Summary information

- **Scientific summary (max. 300 words;** non-confidential format as this may be used for award communication).

Equity, Diversity and Inclusion (EDI) considerations

- **EDI plan (max. 300 words):** EDI plans should describe and demonstrate:
  - Intentional consideration of participant diversity in trial design
  - Justification of exclusions or limitations in representation
  - How site selection, trial design or operational approaches support inclusion of diverse patient populations, where feasible
  - Considerations of equity-related barriers to participation, including geographic access, which may affect recruitment, retention or interpretation of results
  - How multicentre trial design and strategies will enable participation of patients from outside major academic or tertiary care centres, where feasible and appropriate to the study objectives.
  - How existing clinical networks, regional or community-based sites, cooperative groups or established referral pathways will be leveraged to broaden access to participation.
  - Demographic data collection:
    - Identifying relevant demographic data to be collected and justifying their relevance to the study objectives. OICR recommends established standards from CIHI for race and Indigenous identity and gender, sex and sexual orientation.
    - Ensuring demographic data are collected using respectful, voluntary and participant-centred approaches, supported by clear consent and communication.
    - Protecting participant privacy and appropriately managing sensitive or identity-based data.
    - Outlining how demographic data will inform interpretation, safety assessment and future development.
    - Describing plans for analysis and reporting of demographic data, recognizing that analyses may be descriptive in early-phase trials and more evaluative in later-phase studies.
  - Transparency in reporting demographic characteristics and study limitations

OICR recognizes that many OICR-supported clinical trials are small, time-sensitive and exploratory in nature. Applicants are not expected to power studies for subgroup comparisons; however, they are expected to demonstrate intentionality, transparency and good-faith efforts in how demographic diversity, site selection and participant access are considered, implemented, and reported.

EDI plans must include measurable deliverables and reportable milestones. It is not sufficient to merely state that the team will follow home institution EDI policies, nor is it sufficient to state that the home institution serves a diverse population and thus the study population will be diverse.

Study description

- **Protocol synopsis (max. 10 pages,** upload as one PDF): Include a near-final clinical trial protocol, expanding upon the information provided at the Concept stage, and aligns with feedback provided during the Concept review meeting. The information provided at this stage is intended to support development of a penultimate protocol, such that following confirmation of a CATA award, only minor refinements would be required prior to submission for ethics and regulatory approval. It is imperative that the protocol be reviewed and endorsed by i) all named study investigators; ii) appropriate site Clinical Trial Support Units; and iii) relevant pharma and/or biotech partners, including the MRD assay providers. Below is a proposed MRD-enabled clinical trial protocol framework, designed to layer MRD specific requirements onto existing, well accepted protocol standards (e.g., NIH, CCTG). While no specific template is required, all key relevant considerations must be addressed.

  1. Administrative information
  - Protocol title and short title
  - Sponsor
  - Coordinating centre
  - Principal Investigator
  - Participating sites

  2. Study synopsis
  - Disease setting and clinical context
  - Study phase and design
  - Study objectives and hypotheses (including MRD-related hypothesis)
  - Patient population
  - Intervention(s)
  - Endpoints (clinical and MRD-based)
  - Sample size
  - Study duration

  3. Background and rationale
  - Description of the disease and unmet clinical need
  - Current standard of care
  - Summary of existing clinical and translational evidence
  - Current role and maturity of MRD in this disease setting
  - Rationale for inclusion of MRD in this study
  - How the study addresses gaps in current knowledge

  4. Study objectives and endpoints

  4.1 Objectives
  - Primary objective(s)
  - Secondary objective(s)

- Exploratory objectives (including MRD-related objectives)

4.2 Endpoints

- Primary clinical endpoint(s)
- Secondary clinical endpoint(s)
- MRD-based endpoints (clearly defined as primary, secondary, exploratory or surrogate)
- Definitions of MRD response categories

5. Study design

- Overall study design
- Study schema
- Treatment plan and schedule
- Study assessments and timing
- Rules for treatment modification or discontinuation
- Use of MRD results in study conduct (if applicable)

6. Study population

- Inclusion criteria
- Exclusion criteria
- Rationale for key eligibility criteria relevant to MRD interpretation

7. Investigational products and treatment plan

- Description of investigational product(s)
- Treatment plan/schedule of events
- Dosing/dose modification
- Concomitant medications
- Treatment compliance

8. MRD assessments

8.1 MRD context of use

- Intended role of MRD (e.g., prognostic, predictive, response assessment)

8.2 MRD assay description

- Assay platform(s)
- Assay provider(s) or laboratory(ies)
- Analytical performance characteristics (e.g., sensitivity, specificity, LOD)

8.3 Sample collection and handling

- Sample type(s)
- Collection timepoints
- Processing, storage and shipping procedures

8.4 MRD data reporting

- MRD result formats
- Timing of result availability
- Handling of unevaluable or missing MRD data

9. Correlative and translational studies

- Planned correlative analyses
- Relationship to MRD results
- Sample prioritization and use

10. Statistical considerations

- Study hypotheses
- Sample size justification
- Analysis populations
- Statistical methods for clinical endpoints
- Statistical methods for MRD endpoints
- Planned exploratory analyses relating MRD to outcomes

11. Safety monitoring
- Definitions of adverse events
- Safety reporting procedures
- Safety oversight (e.g., DSMB, internal monitoring)

12. Data management
- Data collection methods
- Case report forms
- Data quality control
- Database lock and analysis timelines

13. Quality assurance and monitoring
- Protocol adherence monitoring
- Site monitoring procedures
- MRD assay quality control (where applicable)

14. Ethical considerations
- Informed consent process
- MRD testing disclosure considerations
- Participant confidentiality and data protection

15. Regulatory considerations
- Applicable regulatory framework (e.g., CTA, REB)
- Reporting requirements

16. Publication and data sharing
- Publication policy
- Data sharing principles

17. References

Additional information

- **Differentiation (max. 250 words):** Provide a description on what makes this research unique, better and/or disruptive compared to what other researchers are working on in your field (i.e., what is distinguishing about this research that makes it more attractive than other existing work). This information may be shared with FACIT, OICR's commercialization partner, should the proposal be funded.
- **Data management plan (max. 500 words):** Applicants must provide a data sharing and access plan, as well as a data storage requirements and retention plan, specifying how much data will be generated or transferred into OICR (if applicable) during the course of the project, and the plan for retaining/archiving with the ability to restore the data for the five-year period following its conclusion. Refer to OICR's guidelines on data retention, sharing and open access, located on the OICR Funding Opportunities page for more information. It is expected that study results will be made available through a network data sharing hub to advance the overall goals of an OICR MRD network
- **Use of Artificial Intelligence (AI; max 200 words):** If applicable, applicants must clearly state if and where application material has been generated by AI.

Sensitive Technology Research and Affiliations of Concern Attestation

Regulatory requirements

Common Scientific Outline

Attachments

- **Figures, tables and references:** If applicable, update the file from the Concept stage and upload as one PDF.
- **Letters of Support:** If applicable, update the file from the Concept stage with newly obtained or updated letters, including formal commitments from pharma partners that were not available at the Concept stage, and upload as one PDF.
- **Budget:** If applicable, update the files from the Concept stage and upload as both an Excel and PDF file.
- **Deliverables and Milestones (D/Ms):** Download the template provided in the application and upload as both an Excel and PDF file.
    - D/Ms must include, but are not limited to:
        - Final protocol completion and approval
        - Ethics and Regulatory submission and approval
        - Study activation (at lead and partnering sites)
        - First patient accrued (at lead and partnering sites)
        - Interim analysis (if applicable)
        - Data Safety Monitoring Board meetings
        - Last patient accrued (at lead and participating sites)
        - Study lock
        - Data analysis
    - Clinical Translation's Clinical Trial Timeline Targets must be considered when developing D/M documents, which will be used by CT staff to track clinical trial timelines and progress. In situations where trials are not progressing towards achievement of a deliverable(s) or accruing on target, as evident by bi-annual progress reports and associated D/M updates, the study lead will be expected to meet with CT leadership and outline a plan to ensure study success. If the study continues to encounter issues, CT may consider closing the study, terminating the agreement, and requesting all unspent funds to be returned.
        - Applicants are encouraged to visit the Ontario Cancer Research Ethics Board (OCREB) website to understand and prepare for ethics submission requirements and timelines.
        - Where possible, include milestones that specify go/no-go decision points.
        - Both deliverables and milestones must be measurable and possess a target date for completion (provide the quarter and fiscal year of projected achievement). These deliverables and milestones will be used to measure research progress.

Once all required fields are completed, select the 'Submit Application' button at the bottom of the screen.

3. REVIEW PROCESS

3.1. Administrative review

An administrative review may be completed by the OICR Scientific Secretariat to assess the submission for conformity with the guidelines. Relevant points from the review will be shared with the PI.

3.2. Concept and Full Application review

The review process will take place in three stages, overseen by the CATA Review Committee which is composed of:

- Members of CT's Scientific Advisory Committee
- Members with expertise in oncology, liquid biopsy, MRD and the conduct of clinical trials
- Members of OICR's Patient Community

The review stages are outlined below:

Stage 1: Concept feasibility and scope review
The Committee will evaluate each submitted trial Concept against the defined feasibility criteria and alignment with the scope of the funding competition (refer to **Appendix I**). Concepts that do not meet the criteria or are not deemed to be of sufficiently high priority or merit will not advance. All submitted Concepts will receive feedback.

Stage 2: Concept discussion with the Committee
Prioritized Concepts that pass the initial review will be invited to meet with members of the CATA Review Committee. The purpose of this meeting is to:

- Clarify aspects of the Concept submission.
- Confirm feasibility/fit eligibility and project timelines.
- Justify study budget.
- Discuss areas needing further development.

Once all meetings have been completed, the Committee will determine which Concepts will be invited to submit a Full Application, including a clinical-ready trial protocol. All applicants will receive feedback.

Stage 3: Full Application review
The Committee will review submitted protocols to ensure alignment with the expectations discussed during the meeting with the team.

Appendix I provides an overview of the criteria that will be used by the Committee to evaluate each Concept and Full Application. Decisions made by the Committee are final.

3.3. Notification of Decision

A meeting report summarizing the discussion and recommendation of the CATA Review Committee will be prepared by a Scientific Officer and distributed as part of the Notification of Decision (NOD) that will be provided by December 2026.

4. ESTABLISHMENT OF AGREEMENTS

OICR will establish a funding agreement with the institution of the Lead PI. The Lead PI's host institution will be responsible for execution of sub-agreements with other participating sites. The agreement will cover the general principles regarding the conduct of research activities, eligible research expenses, terms and conditions regarding the disbursement of funds, agreements with third-party funders, financial and progress reporting, PI/Co-PI covenants, IP, commercialization, publications and communication policies. In addition, OICR will establish a commercialization framework, which will require the recipient and OICR to set up an IP co-management plan, where applicable.

Note that delays in execution of research agreements may impact OICR's ability to disburse funds. Funding is contingent upon available funding from the Government of Ontario via the Ministry of Colleges, Universities, Research Excellence and Security. Agreements that are not executed within 45 days will lose funding.

5. REPORTING REQUIREMENTS

5.1. Financial and operational status reporting

The following schedule (**Table 1**) will be used for financial and operational status reporting. Note that deadlines falling on a non-working day will be moved to the next business day. A quarterly reporting template and instructions will be available on the OICR online financial reporting system, CaAwardNet.

Financial Officers of the Lead Institution will be required to provide quarterly updates on budget versus actual expenditures as per the table below. When reporting on the operational status of a project, an explanation of variances of greater than ±15 per cent and mitigation plans to address the budget gaps should be provided.

The OICR fiscal year runs April 1 - March 31. The quarters are as follows:

- Q1: April - June
- Q2: July - September
- Q3: October - December
- Q4: January - March

***Table 1**: Financial and operational status reporting*

Period covered	Responsible party and action	
	Financial Officer	PI at Lead Institution (or designate)
Q1 April-June	Quarterly financial report Due: July 31	Review and submit quarterly financial and operational status report. Due: July 31
Q2 July-September	Quarterly financial report Due: October 31	Review and submit quarterly financial and operational status report. Due: October 31
Q3 October-December	Quarterly financial report Due: January 31	Review and submit quarterly financial and operational status report. Due: January 31
Q4 January-March	Quarterly financial report Due: April 30	Review and submit financial and operational status report. Due: April 30
Q1-Q4 April-March	Annual fiscal year financial report Due: May 31	N/A

5.2. Progress and Key Performance Indicator (KPI) reporting

All projects will be included in OICR's annual reporting process, as required by the Ministry of Colleges, Universities, Research Excellence and Security according to the schedule below (**Table 2**). Note that deadlines falling on a non-working day will be moved to the next business day.

***Table 2**: Reporting requirements*

Report	Period covered	Due date	Person(s) responsible	Action
Progress update	Q3-Q4	Q1	PIs/Co-PIs	Provide status updates on study progress and D/Ms
Progress update	Q1-Q2	Q3	PIs/Co-PIs	Provide status updates on study progress and D/Ms
KPI report	Fiscal year: April-March	April 30 of the subsequent fiscal year	PIs/Co-PIs	Provide quantitative KPIs using ReportNet (OICR's online submission system)

5.3. Post-award reporting

Within five years of the award end date, applicants will be required to submit a post-award report to OICR outlining additional outputs, achievements and impacts of the OICR's funding. Additional details will be provided to applicants in advance of the report being due.

6. COMMUNICATION WITH OICR

The obligations of the investigators to advise OICR of anticipated public dissemination, publications and media announcements will be outlined in the research agreement.

7. ACKNOWLEDGEMENT AND RECOGNITION OF SUPPORT

All investigators and recipient institutions must acknowledge and credit the contribution/support, in whole or part, of OICR and the Government of Ontario in any promotional material, including, without limitation, scientific publications of whatever nature or kind, and in any communication materials or publications supported by OICR funding by referencing the projects/subprojects with the following statement: "This study was conducted with the support of the Ontario Institute for Cancer Research through funding provided by the Government of Ontario. The views expressed in the publication are the views of the authors and do not necessarily reflect those of the Government of Ontario".

8. CONTACT INFORMATION

For any questions, please refer to the FAQ page before contacting the OICR Scientific Secretariat office (ScientificSecretariat@oicr.on.ca).

9. APPENDIX I: EVALUATION CRITERIA AND SCORING

OICR is a signatory to the San Francisco Declaration of Research Assessment (DORA). Reviewers at all stages of the OICR application process are advised that they should consider the quality of the research published and/or proposed in an application. While productivity may be an important factor, the assessment will be based on the content of articles and not the journal impact factor. Furthermore, OICR reviewers are asked to consider the influence of candidates' publications in advancing knowledge in a given field (or throughout biology).

CATA submissions will be reviewed by both scientific and patient partner reviewers.

For patient partner reviewers:
Applications will be reviewed using the following evaluation criteria:

- Assessment of the lay summary
- Feasibility and impact of the proposed patient partnership plan
- Assessment of whether the project addresses a priority question for patients

Table 3 provides a description of each of the above criteria. The merit of each project will be evaluated against the listed criteria, when applicable.

Table 3: Patient partner reviewer evaluation criteria
Assessment of the lay summary • Written in simple terms and plain language, with no excessive jargon, so that it is easily understood by non-specialists. • Provides context for the research, describes the current state of care, addresses the research question or problem to be solved, describes the proposed research and/or methods, clearly states the potential benefit to patients and/or the impact to the field.
Feasibility and impact of the proposed patient partnership plan • Includes evidence that patient partner(s) and/or interested communities have been engaged and have provided input on the lay summary and the research plan. If not, the plan provides a reasonable rationale for patient and/or engagement at a later stage. • Addresses how patient partners or relevant community members/individuals will be engaged throughout the life cycle of the funded research project. • Provides a description of proposed patient/partner engagement including specific contributions they will be expected to make, and the related deliverables and milestones for their work.
Assessment of whether the project addresses a priority question for patients The research addresses a priority question of importance for, or an unmet need of, patients.

Patient partner reviewers will not provide a score in their written reports but will provide a final overall score following the discussion of each project.

For scientific reviewers:
Applications will be reviewed using the following evaluation criteria:

- Relevance
- Excellence
- Potential for impact/path to implementation
- Feasibility

Table 4 provides a description of each criterion. **Table 5** is to be used for scoring. The merit of each project will be evaluated against the listed criteria, where applicable.

Table 4: Evaluation criteria
Relevance - The study: • Clearly aligns with the objectives and scope of the funding opportunity, with MRD as a central and integral component of the trial design. • Addresses a clinically meaningful question in oncology where MRD has the potential to inform patient management or therapeutic decision-making. • Includes a clearly defined MRD-related hypothesis and articulates the intended clinical role of MRD (e.g., prognostic, predictive, response assessment, treatment guidance). • Demonstrates how MRD results are explicitly linked to predefined clinical decision algorithms, management strategies or treatment adaptations (e.g., escalation, de-escalation, modification, duration optimization or avoidance). • Is aligned with the goals of advancing MRD toward clinical utility, implementation, regulatory relevance or future definitive trials. • Reflects alignment with Clinical Translation priorities, including generation of decision-relevant evidence and contribution to the MRD evidentiary pathway

Excellence
• Demonstrates strong scientific and clinical rationale, grounded in current evidence and a clear understanding of the MRD landscape in the selected disease context.
• Presents a well-defined and testable hypothesis, with appropriate study design to address the research question.
• Includes a scientifically justified and fit-for-purpose MRD assessment strategy, including:
  ○ Appropriate assay/platform selection
  ○ Justification of analytical performance characteristics (e.g., sensitivity, specificity, limit of detection)
  ○ Clearly defined MRD-based endpoints
• Uses appropriate and rigorous methodological and statistical approaches, including:
  ○ Justified study design and sample size
  ○ Appropriate analytical methods for MRD and clinical endpoints
• Incorporates relevant correlative and translational studies, where appropriate, to enhance interpretation of MRD findings.
• Demonstrates awareness of current standards of care and competing or complementary trials.

Potential for impact
• Has a clear and credible pathway to clinical, patient and/or health system impact.
• Generates decision-relevant evidence that could inform:
  ○ Clinical decision-making
  ○ Trial design (e.g., future phase II/III studies)
  ○ Regulatory or biomarker qualification pathways
  ○ Clinical guidelines or standard-of-care evolution
• Has the potential to advance MRD toward:
  ○ Clinical integration
  ○ Therapeutic optimization (e.g., escalation/de-escalation strategies)
  ○ Precision oncology approaches
• Clearly articulates how study outcomes will be used beyond the trial itself.
• Demonstrates potential to contribute to broader MRD research efforts (e.g., across Ontario or beyond).
• The EDI and patient partnership plan are appropriate to support the impact of the study. The EDI plan takes into consideration how to accrue a diverse patient population, including participants from historically underrepresented populations. The patient partnership plan takes

Table 4: Evaluation criteria
into consideration the integration of patient partners so that the study meets the needs of the people intended to benefit.

Feasibility
• Demonstrates strong operational readiness and feasibility to initiate and complete the trial within the funding period.
• Includes a realistic and well-supported recruitment plan, with:
  ○ Justified accrual targets.
  ○ Evidence-based projections
  ○ Consideration of competing trials and mitigation strategies
• Is supported by a feasible multicentre design, with:
  ○ Clearly defined roles for participating sites
  ○ Evidence of site engagement and readiness
  ○ Consideration of decentralized or hub-and-spoke models, where appropriate
• Demonstrates MRD assay readiness and operational feasibility, including:
  ○ Availability of assay(s)
  ○ Laboratory and logistical infrastructure
  ○ Acceptable turnaround times aligned with clinical decision-making.
• Includes evidence of partner engagement, where applicable (e.g., assay providers, pharma), supported by letters of support.
• Provides credible and detailed study timelines, including:
  ○ Site activation within expected timelines
  ○ First patient enrollment within approximately seven months of award start
  ○ Completion within the funding period
• Demonstrates appropriate team leadership, experience and study governance, including prior experience with multicentre and MRD-enabled trials.
• The budget is fully justified and appropriate to support the study.
• The deliverables and milestones are attainable within the specified timeline. They are appropriately defined to allow the monitoring of progress against goals and objectives. Appropriate go/no-go decision points are outlined.

Scientific reviewers will submit a preliminary overall score along with their written reports. At the Chair's discretion, these preliminary scores may be used to triage proposals. During the review meeting, both scientific reviewers and patient partner reviewers will provide a final overall score following the discussion of each project. **Table 5** outlines the scoring breakdown and corresponding descriptions.

Table 5: Scoring		
Score	**Descriptor**	**Additional guidance**
4.7-5.0	**Excellent with no weaknesses identified**	Exceptionally strong with essentially no weaknesses. The project excels in most or all criteria. Any shortcomings are minimal. Proposed research has a very high potential for transformative impact on clinical practice and has a very clear path to completion with sufficient funding.

Table 5: Scoring		
Score	**Descriptor**	**Additional guidance**
4.2-4.6	**Excellent with minor weaknesses identified**	Very strong with only some minor weaknesses. The project excels in many criteria and reasonably addresses all others. Certain improvements are possible. Proposed research has a high potential for transformative impact on clinical practice and has a clear path to completion with sufficient funding.
3.6-4.1	**Very good with minor weaknesses identified**	Strong but also some weaknesses. The project excels in some criteria and reasonably addresses all others. Minor revisions are required. Proposed research has a moderate probability for impact on clinical practice and has a reasonably clear path to completion with sufficient funding.
3.0-3.5	**Very good with moderate weaknesses identified**	Strong but also some moderate weaknesses. The project excels in some criteria and reasonably addresses all others. Significant revisions are required. Proposed research has a moderate probability for impact on clinical practice and has a reasonably clear path to completion with sufficient funding.
2.4-2.9	**Good with moderate weaknesses identified**	Some strengths but moderate or major weaknesses identified. The project broadly addresses criteria, but revisions required are too significant to overcome. Proposed research has a moderate to low probability for impact on clinical practice, and the path to completion is missing or not feasible.
Below 2.4	**Unsatisfactory**	Very few strengths and numerous major weaknesses. The project fails to meet most of the criteria and/or has serious inherent flaws or gaps. Proposed research has a low probability for impact on clinical practice. The proposed project should not be funded.